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Lack of Adequate Data on Child Maltreatment Hinders Development of Prevention Programs

Child maltreatment occurs far too often in Washington State, and across the nation, and can lead to serious psychological and physical consequences, including death. The lack of adequate child maltreatment data creates many challenges for those striving to prevent maltreatment. To raise awareness of this problem, this article highlights strengths and weaknesses of current approaches to monitoring child maltreatment in Washington, discusses the need for improved data, and presents possible approaches for expanding surveillance on this important public health issue.

Nationwide, the incidence of child maltreatment is 44 cases per 1,000 children under age 18. State Child Protective Services (CPS) identified approximately 38,500 victims of child maltreatment in Washington during 1997 (Table 1), but the true extent of maltreatment is not fully known. For example, the National Incidence Study (which includes children investigated by CPS agencies, children seen by community professionals but not reported to CPS, and children screened out by CPS without an investigation) found that CPS investigated substantially fewer children than actually experienced harm or endangerment (NIS, 1996). Even the most serious cases—maltreatment deaths—are undercounted. For example, a 1993 study estimated that about 85% of such deaths are recorded as due to other causes (McClain et al., 1993).

In a 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey of Washington adults, 20% of women and 7% of men reported that they had experienced childhood sexual abuse, and 11% of women and 12% of men reported that they had experience childhood physical abuse. These data further support the evidence for undercounting.

Current Approaches to Measurement

Child Protective Service data include the most serious cases and provide detailed information and official verification on those cases referred by professionals or others in the community. However, under-reporting may occur for several reasons. Some parents or caregivers may have the resources or ability to hide abuse. Mandated reporters (e.g., child care workers, teachers, physicians) may lack sufficient training and information on reporting requirements or confidence in the child welfare system. A lack of consensus among community members as to what constitutes maltreatment may contribute to an unknown number of unreported cases. The lack of adequate CPS resources and staffing also may limit investigation of less severe cases of abuse.

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High Domoic Acid Levels Delay Razor Clam Season

Washington's razor clam season has been postponed due to elevated levels of a marine toxin called domoic acid, which causes amnesic shellfish poisoning (ASP), a potentially serious or even life-threatening illness. Symptoms include nausea, vomiting, diarrhea, or abdominal cramps within 24 hours of consuming the clams. In severe cases, neurological symptoms appear within 48 hours and may include headaches, dizziness, disorientation, seizures, breathing difficulty, permanent short-term memory loss, and in some cases death. Neither cooking nor freezing alters the poison and there is no known antidote.

The only previous episode of domoic acid contamination of Washington shellfish occurred in November 1991. Recent tests

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Child Maltreatment *(from page 1)*

School-based surveys of adolescent risk behaviors may offer more complete ascertainment because they don't rely on official agency recognition. These surveys also can provide estimates of maltreatment based on general population samples and can measure health-risk behaviors that can be linked with maltreatment. However, such surveys may lack verified case definitions, they do not provide detailed information about abuse situations, and they depend on self-reports that may be inaccurate.

The 1997 BRFSS telephone survey included questions on prior maltreatment. The population-based sampling design makes it possible to generalize results statewide. Ascertainment of maltreatment is more complete because the survey does not rely on official agency recognition. However, the retrospective and self-reported nature of the responses of adults to questions about maltreatment and the inability to query persons without telephones, those who do not speak English, and persons in the military or institutional settings may affect the accuracy and timeliness of data.

Why Improved Data is Needed

Improved data would allow national, state, and local agencies to make greater progress in reducing maltreatment. For example, better data would allow for:

- Improved ability to monitor the effects of national, state, and local policy changes, such as welfare reform — For example, if child maltreatment rates increase after welfare reform is implemented, it will be important to know whether this is due to an increase in prevalence of abuse and neglect or to increased detection of more at-risk children in child care who are exposed to mandated reporters.
- Improved intervention design and evaluation — Inadequate measurement of child maltreatment hinders ability to determine the success of intervention programs and to design or adjust programs.
- More complete information to policy makers to allow them to appropriately direct resources.
- Improved determination of risk and protective factors — Some of the most commonly discussed risk factors include parental substance abuse, poverty, unemployment, lack of education, and young maternal age. However, the causal associations are not well understood and population-based risk factors have not been clearly identified.

Possible New Approaches

Obtaining adequate child maltreatment data is challenging, but varied measurements with differing strengths and weaknesses can help national, state, and local agencies obtain a more complete picture of the extent of maltreatment. Possible additional approaches include:

- State/local incidence survey — Three National Incidence Surveys have queried mandated reporters (hospital employees, day care providers, school teachers, and CPS employees) to measure maltreatment that may not be reported to CPS. A similar approach could be taken in Washington.
- Additional questions could be added to the BRFSS or school-based student surveys to gather more complete information about maltreatment.
- Household surveys that involved in-person interviews specifically about maltreatment could provide more in-depth information than do surveys like the BRFSS, and could examine links with risk and protective factors and sequelae of abuse.
- Outpatient and hospital data — A University of Washington pilot study identified a set of ICD-9 hospital codes that are consistent with maltreatment. Children hospitalized with these diagnoses were at risk for death due to child homicide or undetermined cause. A similar approach could be applied to outpatient data.
- Improved CPS data — Increased ascertainment might be achieved by increased training for mandated reporters. Providing more information to communities also could improve the rates of appropriate referrals.

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TABLE 1: 1997 CPS data on child maltreatment in Washington

Total referrals to CPS*	79,382
Cases accepted for investigation	43,698
Investigated with in-person contact	35,773
Maltreatment identified	38,500
Children accepted in referrals**	56,281

*Includes duplicate reports
**Includes siblings who may not have experienced maltreatment

Questions? Comments?

For more information, or to comment on this topic, please contact:
Maria Meengs Lathrop in the DOH Office of Child and Adolescent Health/ CHILD Profile, by phone at 360-236-3588 or via e-mail at mnm0303@doh.wa.gov

References

McClain PW, et al: Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics* 1993; 91(2):342.

Sedlack AJ, Broadhurst DD: *National Incidence Study of Child Abuse and Neglect,* Executive Summary. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1996.

Monthly Surveillance Data by County

September 1998* – Washington State Department of Health

County	E. coli O157:H7	Salmonella	Shigella	Hepatitis A	Hepatitis B	Non-A, Non-B Hepatitis	Meningococcal Disease	Pertussis	Tuberculosis	Chlamydia	Gonorrhea	AIDS	Pesticides†	Lead§#
Adams	0	0	0	0	0	0	0	0	1	2	1	0	0	0/0
Asotin	0	0	0	0	0	0	0	0	0	2	0	0	0	0/#
Benton	0	1	0	0	0	0	0	0	1	19	0	0	1	1/18
Chelan	1	0	1	0	0	0	0	0	1	5	2	0	2	1/5
Clallam	0	0	0	0	0	0	0	0	0	4	0	1	0	0/#
Clark	0	5	2	23	3	2	0	1	0	63	6	1	1	0/#
Columbia	0	0	0	0	0	0	0	0	0	0	1	0	0	0/0
Cowlitz	0	1	0	0	0	0	0	0	2	10	0	2	0	2/10
Douglas	0	0	0	0	0	0	0	0	0	3	0	0	0	0/#
Ferry	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Franklin	0	0	0	0	0	0	0	0	0	19	2	1	0	0/#
Garfield	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Grant	0	0	0	1	0	0	0	0	1	6	0	0	2	0/#
Grays Harbor	0	2	1	1	0	0	1	0	0	21	0	0	0	0/#
Island	0	1	0	0	0	0	0	0	0	13	0	0	0	0/#
Jefferson	0	0	0	2	0	0	0	0	0	1	0	0	0	0/0
King	14	43	21	28	14	1	0	1	12	358	100	12	4	2/49
Kitsap	1	5	1	1	0	0	0	7	1	52	8	0	2	0/32
Kittitas	0	0	1	0	0	0	0	0	0	4	0	0	1	0/0
Klickitat	0	0	0	0	0	0	0	0	0	0	0	1	0	0/0
Lewis	1	0	0	0	0	0	0	0	0	5	1	0	0	0/#
Lincoln	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Mason	0	2	0	0	0	0	0	4	0	8	0	0	0	0/0
Okanogan	0	0	0	0	0	0	0	0	0	6	1	0	3	0/#
Pacific	0	0	0	0	0	0	0	0	0	1	0	0	0	0/0
Pend Oreille	0	0	0	0	0	0	0	0	0	2	1	0	0	0/0
Pierce	3	0	2	2	2	0	0	9	0	172	40	3	3	0/59
San Juan	0	0	0	0	0	0	0	0	0	2	0	0	0	0/0
Skagit	0	0	0	0	0	0	1	0	0	23	4	0	0	0/6
Skamania	0	0	0	0	0	0	0	0	0	2	0	0	0	0/0
Snohomish	2	10	5	3	0	1	0	1	2	102	24	0	3	1/26
Spokane	0	2	1	30	0	0	0	0	3	69	7	4	1	4/27
Stevens	0	0	0	1	0	0	0	0	0	3	0	0	0	0/0
Thurston	2	5	2	0	0	0	0	2	0	42	8	2	0	0/22
Wahkiakum	0	0	0	0	0	0	0	0	0	0	0	1	0	0/0
Walla Walla	0	1	1	0	0	0	0	0	0	14	0	0	0	0/#
Whatcom	5	5	1	2	0	0	0	2	1	30	1	1	1	0/9
Whitman	0	1	0	0	0	0	0	0	0	7	0	0	1	0/#
Yakima	1	13	29	0	1	0	2	7	0	66	8	0	4	0/10
Unknown														0/1
Current Month	30	97	68	94	20	4	4	34	25	1137	215	29	29	11/294
September 1997	20	49	12	73	5	2	2	37	22	785	193	68	36	18/315
1998 to date	72	389	154	837	85	17	55	256	197	8365	1463	309	376	100/2573
1997 to date	73	438	194	441	57	22	68	288	236	6800	1450	480	326	122/3262

* Data are provisional based on reports received as of September 30, unless otherwise noted.

† Unconfirmed reports of illness associated with pesticide exposure.

§# Number of elevated tests (data include unconfirmed reports) / total tests performed (not number of children tested); number of tests per county indicates county of health care provider, not county of residence for children tested; # means fewer than 5 tests performed, number omitted for confidentiality reasons.

Gov. Locke Appoints Mary Selecky Acting Secretary of Health

Governor Gary Locke has appointed Mary C. Selecky of Colville as acting secretary of the Department of Health. She is the administrator of the Northeast Tri-County Health District, which serves Ferry, Pend Oreille, and Stevens counties. She has held that position since 1979 and is a state and national leader on the local role in public health issues. Selecky assumed her new duties October 5 and will serve until a permanent secretary is named.

WWW
Access Tips

The National Clearinghouse on Child Abuse and Neglect Web site is at: http://www.calib.com/nccanch
For more information on domoic acid levels in shellfish, visit the DOH Web site at: http://www.doh.wa.gov — click on "What's New"

Changes in Distribution of *epiTRENDS* ▼

A need to reduce publication costs requires that we reduce the number of copies sent to a single address. Beginning with this issue, one copy will go to the first alphabetical contact at each address. We ask that recipients make copies or route the issue. Or, we can send you the bulletin via email. For more information, contact Candy Holstine at cmh0303@doh.wa.gov or 360-236-4243.

Razor Clams *(from page 1)*

indicate that levels of domoic acid have reached record high levels in razor clams, with the highest reading of 287 parts per million (ppm) in clams sampled at Kalaloch in Jefferson County. Harvesting is closed whenever the level rises above 15 ppm.

Domoic acid is a neurotoxin that can occur in a type of phytoplankton ingested by some species of fish and shellfish. Earlier this year high domoic acid levels in sardines and anchovies in California's Monterey Bay resulted in the death of more than 50 sea lions that ate the toxic fish. In recent months California, Oregon, and British Columbia have closed shellfish areas due to elevated levels of domoic acid.

Razor clam sampling and testing will continue through the fall and winter along the Washington coast and harvesting will not be allowed until domoic acid levels fall below 15 ppm. At present there are no safe (or legal) sources of fresh razor clams in Washington. Also considered unsafe are mussels, hardshell clams, and other shellfish from any beach on the outside coast. Domoic acid can also affect coastal populations of Dungeness crab, which feed on razor clams. Samples of crab will be tested for the toxin prior to the opening of the commercial crab season on the coast. Routine tests have shown that the commercial shellfish from coastal bays and other Washington waters have not been affected by domoic acid and are safe to eat.

Suspected cases of ASP should be reported immediately to the DOH Office of Shellfish Programs. Contact Ned Therien at 360-236-3326 (nct0303@doh.wa.gov) or Patti Waller, 206-361-283 (plw0303@doh.wa.gov).

Child Maltreatment *(from page 2)*

Other approaches might be developed, including directly asking children about their experiences and surveying mandated providers about their referral practices. To obtain a more complete and accurate picture of child maltreament, multiple methods of data collection will be needed.

The lack of adequate child maltreatment data remains a huge gap in the public health monitoring system in all states and limits state and local efforts to prevent abuse. Closure of this gap will require commitment of resources and more focused attention on the problem. A first step is to stimulate discussions among all groups concerned with this issue and to explore possible solutions.

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